Antepartum Haemorrhage, Placental Abruption and Extreme Prematurity: A Case Study.

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Background

Antepartum haemorrhage (APH) complicates up to 5% of all pregnancies and is one of the leading causes of perinatal and maternal mortality worldwide[1]. There are a variety of different causes for APH though the most significant reasons include placental abruption and placenta previa. Some risk factors for abruption include previous abruption, advanced maternal age, assisted reproductive technology, hypertensive diseases, abdominal trauma, smoking and cocaine use[1].

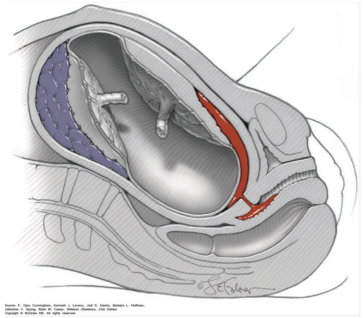

Figure 1. Left placenta shows complete abruption with concealed haemorrhage. Right shows partial abruption with blood and clots which dissect the decidua and reach the internal cervical os then the vagina [2].

Case

SA was a 40 year old G1P0 at 20 weeks gestation via IVF who was admitted with a small volume APH. She remained an inpatient with regular small volume bleeds, normal fetal monitoring along with normal fetal growth and wellbeing on weekly MFM ultrasounds. SA was steroid loaded at 22+6 weeks when her bleeding increased and viability was approaching. At 24+2 weeks she experienced a large volume bleed with associated abdominal pain, rigidity and an abnormal ctg showing repetitive complicated decelerations. A speculum examination revealed an open and dilated cervix. As fetal viability was now compromised and a diagnosis of abruption suspected she was transferred to the operating room for an emergency caesarean section under general anaesthesia. A live male neonate was born with good tone and effort and was attended to immediately by the NICU team. SA recovered without haematological or postnatal complications. Her baby remained in NICU for 13 weeks.

Discussion

Women with modifiable risk factors for APH should be encouraged to modify these so to reduce the risk of abruption. In cases of extreme prematurity such as this, a multidisciplinary team including senior obstetricians and neonatologists should be involved in counselling the woman regarding viability, NICU admission and future quality of life of the neonate. In all cases, maternal wellbeing is the priority and delivery needs to be considered with life threatening haemorrhage and haemodynamic instability. As Haemorrage is the major cause of severe maternal morbidity in almost all ‘near miss’ situations in developed and developing countries APH needs to be thoroughly investigated and managed to prevent maternal death and complications [1].

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Reference:

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